PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 10/10/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Non-small cell lung cancer (NSCLC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

3. Is the disease T790M negative? **Y** ☐ **N** ☐

4. Is there evidence of either unacceptable toxicity or disease progression while on the current regimen?
   - Yes, unacceptable toxicity (If checked, no further questions) ☐
   - Yes, disease progression (If checked, no further questions) ☐
   - No (If checked, no further questions) ☐

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

6. In which clinical setting will the requested medication be used?
   - Advanced disease (If checked, go to 7) ☐
   - Metastatic disease (If checked, go to 7) ☐
   - Recurrent disease (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

7. Does the patient have a sensitizing epidermal growth factor receptor (EGFR) mutation? ACTION REQUIRED: If Yes, chart note(s) or test results of documentation of EGFR mutation must be submitted.
   - Yes (If checked, go to 8) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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